

DSRIP Statewide Learning Collaborative Summit

Highlights of DSRIP Projects

**Moderator: Kay Ghahremani, Associate Commissioner for
Medicaid/CHIP, HHSC**

- Bren Manaugh, MSW, LCSW, CPHQ, Center for Healthcare Services, San Antonio
- Angie Hochhalter, PhD, Scott & White Memorial Hospital
- Hector Gonzalez, M.D., City of Laredo Health Dept.
- Sid O'Bryant, PhD., University of North Texas Health Science Center
- Billie Bell, Medina Healthcare System
- Kate Philley Starnes, JD, MEd, University of Texas Health Science Center at Tyler



Behavioral Health Super-Utilizers Program in Bexar County



The Center for Health Care Services
San Antonio

Standard Approach	Integrated Care for SuperUtilizers
Assume Quadrant Model (High Medical/High Psychiatric Needs)	Complex Psychosocial Needs incl. Housing; Trauma history; Axis II/Personality Disorders
Silo'd Providers and Care System	Integrated; Multidisciplinary; Community Coordinated
Focus on Pathology	Strengths-Based/Recovery Model
Driven by contract requirements/revenue	Driven by needs of the person served
Setting-determined and -limited	Person-centered/ <i>in vivo</i>
Non-compliance/exclusion	Engagement/inclusion/retention
System-driven/productivity goals	Person-centered/quality outcomes
Individual Professional Services	Value-added Groups; Peer Services
Re-traumatizing and alienating	Trauma-Informed



Bell County Patient Navigation Program

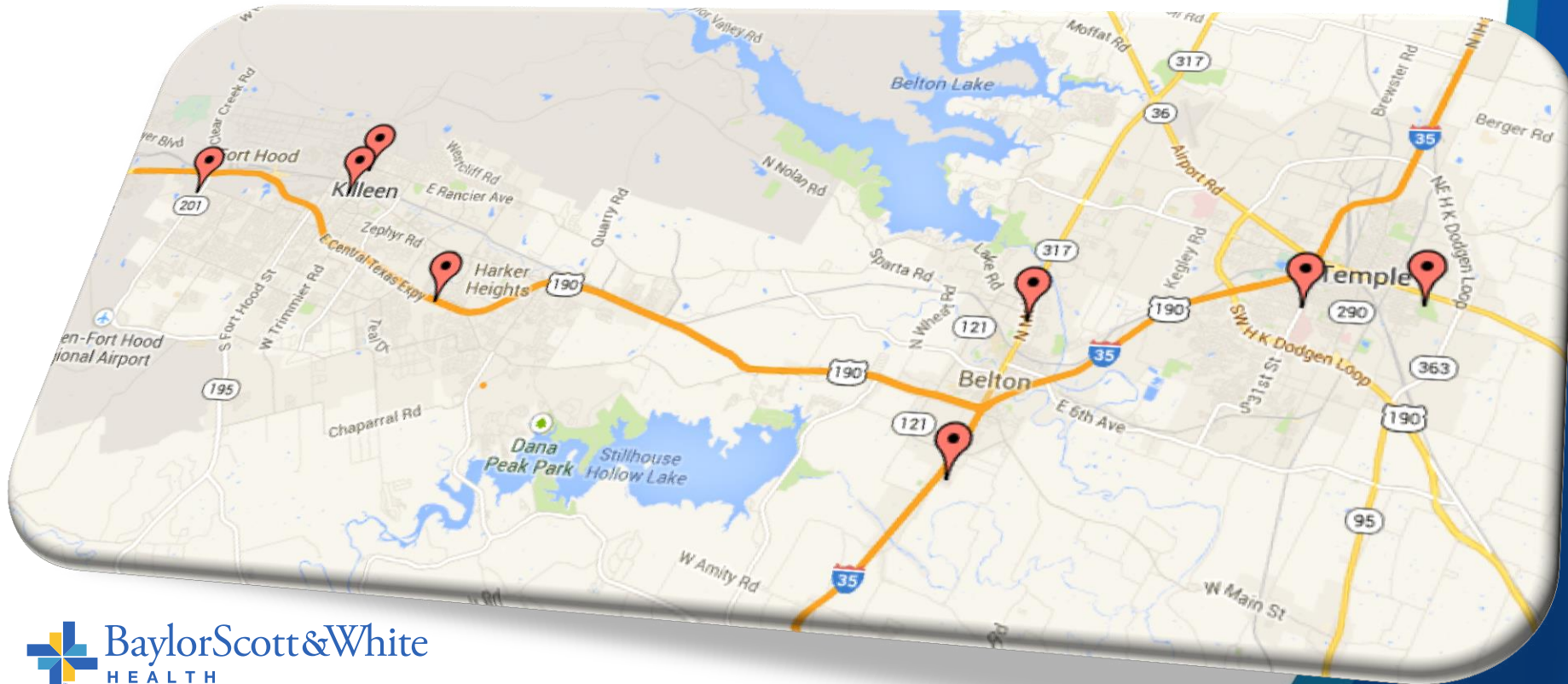
A collaborative 1115 Waiver DSRIP Program:

Scott & White Memorial Hospital
Bell County Indigent Health Care Program
Metroplex Hospital
Cedar Crest Hospital & RTC
Greater Killeen Free Clinic
Temple Community Free Clinic
Central Texas Area Agency on Aging

Partnering with Seton Medical Center Harker Heights
(Year 3 Project)

Prevent Avoidable ED Visits by Connecting Individuals to Needed Services

- Navigators and services embedded across County
- 2 Tiers based on need
- Additional mental health support (NP, LMSW)
- Chronic illness self-management education





Provides comprehensive primary care and early detection screening and preventive health services for chronic disease care (patients at risk or with diabetes, high cholesterol, high blood pressure, metabolic syndrome).

Expand the Chronic Care Model to Primary Care (137917401.2.1)

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Health Director

- **Expanded Primary Care Capacity to 2,519 patients** of which 94 were new patients to address diabetes prevention and obesity reduction (beyond the 25 required in our metric).
 - A Family Nurse Practitioner, Licensed Vocational Nurse and a Medical Office assistant were hired to provide expanded services as well added three (3) new clinics.
- Integrated disease self management (DSM) activities into chronic disease services, early detection screening and preventive care services.
- Trained providers and staff on chronic disease management
- **Metric 1-17.1 Expanded Chronic Care Model to Primary Care:**
 - 106 primary care patients have been integrated into DSM which exceeds our metric of 25.
 - DSM policy was developed for chronic disease primary care clinicians to integrate DSM for all at risk and/or confirmed persons with a chronic disease (diabetes, hypertension, metabolic syndrome).
 - DSM provides nutrition, healthier cooking services, physical activity and case management by a team of a nurse, nutritionist and case manager.
- **Category III related activities:**
 - **Prevent Diabetes complications:** 186 patients with diabetes were tracked and none were hospitalized for short term complications for 1 October 2013 through 31 March 2014.
 - Will now use the metric to reduce the number of patients with A1C levels >10 (IT-1.10) impacting another 115 patients to reduce risk of diabetes through this early detection and DSM
 - **Increase number of patients 18-75 years of age with DM with BP levels <140/80** by at least 5 patients each year, we have also reached this metric as well. This will help reduce hospital admission due to HBP and its complications.

